APPLICATION FOR ACTIVE MEDICAL PHYSICIAN ASSISTANT STAFF

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

To process your application for medical staff privileges with OCSHCN, please return the following:

- ☐ Application for Active Medical Physician Assistant (form OCSHCN-60d) Please sign and date (see last page)
- ☐ Signed Authorization, Attestation, and Release (form OCSHCN-60e)
- ☐ Signed Anti-Harassment and Discrimination Acknowledgment (form OCSHCN-60f)
- ☐ Current credentialing from the National Commission on Certification of Physician Assistants (NCCPA)
- ☐ Copy of the Collaborative Practice Agreement between the physician and yourself
- ☐ Copy of your current CAQH application
- ☐ Current Curriculum Vitae
- ☐ Copy of current malpractice insurance endorsement
- ☐ Copy of current Kentucky State license
- ☐ Copy of current DEA certificate (if applicable)

PERSONAL INFORMATION:

Name: (Last) _____ (First) _____ (MI) __

Professional Degree _____ DOB _____

KY State License Number _____ KY Medicaid Number _____

Practice Name _____

Office Address _____
City State Zip Code Country

Office Phone _____ Office Fax_____

Preferred E-mail _____

CLINICAL PRIVILEGES REQUESTED

_____
_____
_____

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PEER REFERENCES: Please provide two (2) names of physicians or physician assistants, along with their institution, who have worked closely with you, and can comment on your professional skills.

I certify that all information provided by me in my application is current, true, correct, accurate, and complete to the best of my knowledge and belief, and is furnished in good faith. I certify that I have received a copy of the Medical Staff Policies. In making application for appointment to OCSHCN, I agree to abide by its medical staff's bylaws, rules and policies, to conduct my practice in accordance with high ethical traditions, and I pledge to provide continuous care for all my patients.

I further acknowledge and understand that my application does not guarantee that OCSHCN will grant me clinical privileges or contract with me as a provider of service.

_____
Printed Name

_____ _____
Signature Date

Institution Name_____

Institution Address _____
City State Zip Code Country

Name: (Last) _____ (First) _____ (MI) __

Institution Name_____

Institution Address _____
City State Zip Code Country

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Please answer the following questions. For any "Yes" response, give full details on a separate sheet and attach to your application.

1	Has your license to practice as a physician assistant in any jurisdiction ever been denied, suspended, limited, revoked, or surrendered?	Yes ☐ No ☐
2	Has your DEA license ever been denied, suspended, limited, revoked, or surrendered?	Yes ☐ No ☐
3	Have you ever been convicted of a felony?	Yes ☐ No ☐
4	Have your privileges at any hospital or institution ever been denied, suspended, limited, revoked or not renewed (for other than administrative reasons)?	Yes ☐ No ☐
5	Have you ever resigned from a hospital staff or institution while under investigation regarding a breach of professional activity?	Yes ☐ No ☐
6	Have you ever been denied membership or a renewal thereof or been subject to disciplinary proceedings in any medical organization?	Yes ☐ No ☐
7	Are you now abusing, or have you ever been treated for abuse of, chemical substances?	Yes ☐ No ☐
8	Do you carry Medical Liability Insurance in an amount and kind that will insure protection of OCSHCN patients under your care?	Yes ☐ No ☐
9	Any claims within past 5 years?	Yes ☐ No ☐
10	Are there any pending claims?	Yes ☐ No ☐
11	Have you ever had malpractice or liability insurance coverage suspended or denied?	Yes ☐ No ☐

NOTE: If there is any other significant information not asked on this page that should be known by the committee evaluating your eligibility for staff membership, please provide as an attachment to this application.

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_____

Printed Name

_____ _____

Signature Date